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November 28, 2017

Green Mountain Care Board
State of Vermont
89 Main Street, Third Floor, City Center
Montpelier, VT 05620

Re: MVP VT LG HMO Filing 1Q/2Q 2018 - Abbreviated Report
SERFF #: MVPH-131213366

The purpose of this letter is to provide an abbreviated summary and recommendation regarding the large group filing submitted by MVP Health Plan (MVP) for its existing HMO products for the first and second quarters of 2018 and to assist the Board in assessing whether to approve, modify, or disapprove the request. We are performing an abbreviated review because currently no policyholders are affected by this filing.

Filing Description

1. This filing demonstrates the premium rate development of MVP's large group HMO product portfolio and includes proposed rates for both the first and second quarters of 2018.

2. There are currently no members enrolled in these plans. The proposed rate increase would only affect Vermont large groups that purchase HMO coverage from MVP during the first half of 2018.

3. The manual rates proposed in this filing represent a reduction compared to the rates previously approved in the filing MVPH-130977835. The changes also affect the rate calculation for experience-rated groups. The rate impact of this filing differs by group depending on the level of experience credibility and on other factors.

4. The requested first and second quarter rate changes are shown below, separated by fully manually rated and fully experience rated. Note that groups with 50 to 1,000 members are partially credible and would receive a blend of these two rate increases.

For a 100% Manually rated group:

Sources of Rate Change for Manual Rate Portion	Annual 1Q18 / 1Q17	Annual 2Q18 / 2Q17	Quarterly 1Q18 / 4Q17	Quarterly 2Q18 / 1Q18
Manual Rate Change[1]	-5.6%	-5.4%	-8.7%	1.4%
Age/Gender Factor Changes	-1.4%	-1.4%	-0.1%	0.0%
Changes in Target Retention	0.9%	0.7%	0.25%	0.0%
Total Revenue Change	***-6.1%***	***-6.1%***	***-8.6%***	***1.4%***

For a 100% Experience-rated group:

Sources of Rate Change for Experience Rated Portion	Annual 1Q18 / 1Q17	Annual 2Q18 / 2Q17	Quarterly 1Q18 / 4Q17	Quarterly 2Q18 / 1Q18
Experience-Rated Trend[2]	5.0%	5.0%	1.2%	1.2%
Changes in Target Retention	0.9%	0.7%	0.25%	0.0%
Total Revenue Change	***6.0%***	***5.8%***	***1.5%***	***1.2%***

Standard of Review

Pursuant to Green Mountain Care Board (Board) Rule 2.000 Health Insurance Rate Review, this letter is to assist the Board in determining whether the requested rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the law, and is not excessive, inadequate, or unfairly discriminatory.

Summary of the Data Received

MVP provided the proposed manual rates, which are based on the manual rate calculated for the HIC block as filed in MVPH-131148723. In addition, the filing includes the experience rating formula and all applicable rating factors, including industry factors and plan design factors. MVP also provided an updated trend table for experience-rated groups, reflecting updated information regarding provider reimbursement arrangements.

Company's Analysis

1. *Rate Development:* There are currently no active groups in this block. MVP anticipates moving all groups in the HIC (PPO) block onto this block, starting with policy renewals April 1st and later. As a result, the base period experience underlying the proposed rates is from that block, not HMO business. The development of the overall rate level is documented in the filing MVPH-131148723.

   The primary difference in the proposed rates and the HIC rates is that the plan designs offered in the HMO block differ from those offered in the HIC block. In general, the HMO plans have richer benefits and lower copays than the HIC plans. MVP used the richest HIC plan and adjusted for differences in copays,

[1] The manual rate change of 1.1% per quarter has already been approved, as the previous filing reflected manual rates for all 4 quarters in 2017.

[2] The experience is trended separately for medical and Rx claims. This estimate of the total impact reflects MVP's most recent PPO experience, but would vary slightly based on a group's actual breakdown of medical and Rx claims.

coinsurance, and other benefit characteristics to calculate the proposed HMO rates.

In addition to the primary medical plans, there are a number of prescription riders and other riders available to supplement the base coverage. The rates for these riders were updated to reflect HIC experience as well, where such experience was available. The rate changes on the riders range from approximately a $8 decrease to a $2 increase PMPM. If no data is available for a given rider, the rate change is 0%.

2. *Age/Gender Factor Changes:* There is no current enrollment on this block, and the age/gender factors from the 1Q/2Q 2018 PPO filing are being proposed. These factors are 0.1% lower than the factors previously approved for the HMO products.

3. *Medical Trend:* This filing reflects MVP's desire to update the trend applied to a group's experience when setting large group rates. The proposed trend levels, as well as the previously approved trend levels, are summarized in the table below:

Experience Allowed Medical Trends		
Year	**Current**	**Proposed**
2016	1.7%	1.7%
2017	4.7%	2.7%
2018	4.7%	3.3%
2019+	4.7%	3.4%

The proposed experience medical trends reflect unit cost increases as well as anticipated increases in utilization. In addition to the allowed trends shown above, there is an additional 0.1% annual trend to reflect the impact of deductible leveraging[3]. The proposed trend is consistent with the trend filed and supported in the Large Group PPO filing MVPH-131148723.

4. *Rx Trend:* Similar to the medical trend, MVP is requesting a modification to the previously approved Rx trend for the experience-rated groups. The proposed changes to the Rx trend assumptions are summarized below.

Experience Paid Rx Trends		
Year	**Current**	**Proposed**
2016	14.6%	14.6%
2017	14.5%	10.7%
2018	14.7%	12.8%
2019+	14.7%	13.0%

The proposed experience trends are consistent with the Rx trend filed and supported in the Large Group PPO filing MVPH-131148723.

5. *Retention Assumptions:* Retention incorporates all non-claim expenses built into the proposed rates, including administrative costs and contribution to surplus. As in the prior approved filing, retention charges

[3] Leveraging is the result of the fixed nature of deductibles and copays causing the carrier to bear a greater portion of the cost of the medical inflation than the insured.

are added to the blended pure premium in deriving the group required premium. The Experience Rating Addendum contains all expenses that will be added to the projected claims to calculate total premium. The retention charges include 9.7% of premium for general administrative expense. This is the same as for the 3Q and 4Q of 2017 filing.

L&E Analysis

1. *Rate Development:* The HMO block has had no enrolled members for over a year. For this reason, the experience from the PPO block is being used to set the rates. MVP is encouraging members from the PPO block to move to the HMO block, meaning the same members may be covered. Also, the proposed rates by plan were developed using a relativity to an EPO plan on the PPO block, meaning that the out-of-network benefits are effectively identical. The copays and other cost sharing of the HMO plans were compared to the EPO plan VE2-085. This plan has very similar benefits to the HMO plans, and the method used to set the HMO plan factors is reasonable. L&E asked MVP what impact members would experience if they switched from the PPO plan to the new EPO/HMO plan. MVP stated that they would not notice, as there are no network or prior authorization differences between the two lines of business. The only difference appears to be that the HMO block does not offer the HDHP and other leaner benefit designs currently available on the PPO block. We believe MVP's use of the PPO experience is reasonable.

2. *Age/Gender Factor Changes:* The age/gender factors proposed in this filing are 0.1% lower than the previously approved factors, due to changes in the enrollment mix of members enrolled in the PPO product. Because the projected claims are based on the PPO experience, it is necessary that the age factors be normalized to be on a consistent basis. This adjustment is further supported in the PPO filing MVPH-131148723.

3. *Medical Trend:* We consider the development of 2017 medical trend using negotiated unit cost change with providers and GMCB approved rate changes to be reasonable and appropriate. We consider the 3.4% annual medical paid trend assumption to be reasonable and appropriate.

   The proposed trend rates are lower than previously assumed. This is due in large part to the proposed trend factors reflected the Board's orders to Vermont hospitals regarding the 2018 budgets. The medical trend includes a utilization component, which has been reviewed at length in the prior filing MVPH-131034103 and is reasonable.

4. *Rx Trend:* MVP analyzes its pharmacy data by drug category (Generic, Brand, Specialty). Annual trend factors by drug category were supplied by MVP's pharmacy vendor and account for MVP's Vermont specific book of business.

   As there is no recent claims experience on this block, the drug trends were weighted using the data from the large group PPO filing. We believe this methodology is reasonable and appropriate.

5. *Administrative Expenses:* We observed MVP's assumed general administrative load of 9.7% to be the same as in the previous filing. This assumption is also consistent with the recently filed PPO product, where it was reviewed and found to be reasonable and appropriate.

   The proposed contribution to surplus is 2.0%. In some past orders, the Board has reduced the proposed contribution to surplus from 2.0% to 1.0%. Due to the relatively small size of the large group block, L&E recommends that the assumption not be reduced to protect the company from inherent volatility.

   One of the non-benefit expenses included in the rate development is the New York HCRA surcharge. The surcharge is applicable to all claims processed by hospitals in the state of New York, regardless of

whether the patient is a New York resident. A small portion of MVP's Vermont members utilize New York hospitals, resulting in surcharge payments for those individuals. The result is a 0.25% load on the projected claims, or approximately $1 PMPM. This amount is based on MVP's actual historical Vermont claims and is reasonable.

In the prior filing, the HCA billback was included in the manual rate development as a non-claim expense. Consistent with the recent large group PPO filing, MVP maintains that this amount should be considered a claim expense. It has therefore been removed from the non-claim loads included in the Experience Rated Addendum. In the PPO filing, this was counteracted by an increase in the claims cost. Because the proposed rates are based on the PPO rates, that increase has flowed through to the proposed HMO rates.

While we do not agree with MVP's inclusion of these costs in the projection of medical costs, the proposed rates are compliant with all applicable loss ratio requirements regardless of how the billback is reported. As such, the decision to report this cost as medical expense is not within the scope of this filing.

MVP's projected administrative expenses are reasonable and appropriate.

Recommendation
The proposed manual rates and experience-rating methodology are reasonable. We recommend approval of this filing as proposed by the Company.

The impact of this filing, on manually-rated and experience rated groups, is summarized below. For groups with partial credibility (large groups with fewer than 1,000 members), the actual impact would be in the middle. As no members are currently enrolled, these figures are theoretical representations of the rate increase that would be experienced if a member was currently enrolled.

For a 100% Manually rated group:

Sources of Rate Change for Manual Rate Portion	Annual 1Q18 / 1Q17	Annual 2Q18 / 2Q17	Quarterly 1Q18 / 4Q17	Quarterly 2Q18 / 1Q18
Manual Rate Change[4]	-5.6%	-5.4%	-8.7%	1.4%
Age/Gender Factor Changes	-1.4%	-1.4%	-0.1%	0.0%
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Total Revenue Change	***-6.1%***	***-6.1%***	***-8.6%***	***1.4%***

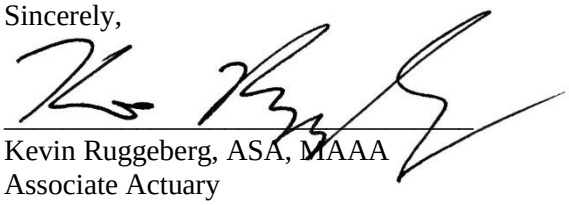
For a 100% Experience-rated group:

Sources of Rate Change for Experience Rated Portion	Annual 1Q18 / 1Q17	Annual 2Q18 / 2Q17	Quarterly 1Q18 / 4Q17	Quarterly 2Q18 / 1Q18
Experience-Rated Trend[5]	5.0%	5.0%	1.2%	1.2%
Changes in Target Retention	0.9%	0.7%	0.25%	0.0%
Total Revenue Change	***6.0%***	***5.8%***	***1.5%***	***1.2%***

[4] The manual rate change of 1.1% per quarter has already been approved, as the previous filing reflected manual rates for all 4 quarters in 2017.

[5] The experience is trended separately for medical and Rx claims. This estimate of the total impact reflects MVP's most recent HMO experience, but would vary slightly based on a group's actual breakdown of medical and Rx claims.

Sincerely,



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ASOP 41 Disclosures
The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[6], promulgates actuarial standards of practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct[7], to observe the ASOPs of the ASB when practicing in the United States. ASOP 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

Identification of the Responsible Actuary
The responsible actuaries are:

- Kevin J. Ruggeberg, ASA, MAAA, Associate Actuary at Lewis & Ellis, Inc. (L&E).
- Jacqueline B. Lee, FSA, MAAA, Vice President & Principal at Lewis & Ellis, Inc. (L&E).
- David M. Dillon, FSA, MAAA, MS, Vice President & Principal at Lewis & Ellis, Inc. (L&E).

These actuaries are available to provide supplementary information and explanation. The actuaries also acknowledge that they may be acting as an advocate.

Identification of Actuarial Documents
The date of this document is November 28, 2017. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is March 28, 2016.

Disclosures in Actuarial Reports

- The contents of this report are intended for the use of the Green Mountain Care Board. The authors of this report are aware that it will be distributed to third parties. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.
- Lewis & Ellis Inc. is financially and organizationally independent from the health insurance issuers whose rate filings were reviewed. There is nothing that would impair or seem to impair the objectivity of the work.
- The purpose of this report is to assist the Board in assessing whether to approve, modify, or disapprove the rate filing.
- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.
- Lewis & Ellis has reviewed the data provided by the issuers for reasonableness, but we have not audited it. L&E nor the responsible actuaries assume responsibility for these items that may have a material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.
- We are not aware of any subsequent events that may have a material effect on the findings.
- There are no other documents or files that accompany this report.
- The findings of this report are enclosed herein.

[6] The American Academy of Actuaries (Academy), the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, the Conference of Consulting Actuaries, and the Society of Actuaries.

[7] These organizations adopted identical *Codes of Professional Conduct* effective January 1, 2001.

Actuarial Findings
The actuarial findings of the report can be found in the body of this report.

Methods, Procedures, Assumptions, and Data
The methods, procedures, assumptions and data used by the actuary can be found in body of this report.

Assumptions or Methods Prescribed by Law
This report was prepared as prescribed by applicable law, statues, regulations and other legally binding authority.

Responsibility for Assumptions and Methods
The actuaries do not disclaim responsibility for material assumptions or methods.

Deviation from the Guidance of an ASOP
The actuaries have not deviated materially from the guidance set forth in an applicable ASOP.